SEC. 1103. SPECIAL RULES FOR HOME AND COMMUNITY-BASED LONG-TERM CARE SERVICES.

(a) QUALIFYING INDIVIDUALS.—For purposes of section 1101(a)(5)(C), individuals described in this subsection are the following individuals:

(1) ADULTS.—Individuals 18 years of age or older determined (in a manner specified by the Board)—

(A) to be unable to perform, without the assistance of an individual, at least 2 of the following 5 activities of daily living (or who has a similar level of disability due to cognitive impairment)—

(i) bathing;

(ii) eating;

(iii) dressing;

(iv) toileting; and

(v) transferring in and out of a bed or in and out of a chair;

(B) due to cognitive or mental impairments, to require supervision because the individual behaves in a manner that poses health or safety hazards to himself or herself or others; or

(C) due to cognitive or mental impairments, to require queuing to perform activities of daily living.

(2) CHILDREN.—Individuals under 18 years of age determined (in a manner specified by the Board) to meet such alternative standard of disability for children as the Board develops. Such alternative standard shall be comparable to the standard for adults and appropriate for children.

(b) LIMIT ON SERVICES.—

(1) IN GENERAL.—The aggregate expenditures by a State health security program with respect to home and community-based long-term care services in a period (specified by the Board) may not exceed 65 percent (or such alternative ratio as the Board establishes under paragraph (2)) of the average of the amount of payment that would have been made under the program during the period if all the home-based long-term care beneficiaries had been residents of nursing facilities in the same area in which the services were provided.

(2) ALTERNATIVE RATIO.—The Board may establish for purposes of paragraph (1) an alternative ratio (of payments for home and community-based long term care services to payments for nursing facility services) as the Board determines to be more consistent with the goal of providing cost-effective long-term care in the most appropriate and least restrictive setting.

SEC. 1104. EXCLUSIONS AND LIMITATIONS.

(a) IN GENERAL.—Subject to section 1101(e), benefits for service are not available under this title unless the services meet the standards specified in section 1101(a).

(b) SPECIAL DELIVERY REQUIREMENTS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT SERVICES PROVIDED TO AT-RISK CHILDREN.—

(1) REQUIRING SERVICES TO BE PROVIDED THROUGH ORGANIZED SYSTEMS OF CARE.—A State health security program shall ensure that mental health services and substance abuse treatment services are furnished through an organized system of care, as described in paragraph (2), if—

(A) the services are provided to an individual less than 22 years of age;

(B) the individual has a serious emotional disturbance or a substance abuse disorder; and

(C) the individual is, or is at imminent risk of being, subject to the authority of, or in need of the services of, at least 1 public agency that serves the needs of children, including an agency involved with child welfare, special education, juvenile justice, or criminal justice.

(2) REQUIREMENTS FOR SYSTEM OF CARE.—In this subsection, an ''organized system of care'' is a community-based service delivery network, which may consist of public and private providers, that meets the following requirements:

(A) The system has established linkages with existing mental health services and substance abuse treatment service delivery programs in the plan service area (or is in the process of developing or operating a system with appropriate public agencies in the area to coordinate the delivery of such services to individuals in the area).

(B) The system provides for the participation and coordination of multiple agencies and providers that serve the needs of children in the area, including agencies and providers involved with child welfare, education, juvenile justice, criminal justice, health care, mental health, and substance abuse prevention and treatment.

(C) The system provides for the involvement of the families of children to whom mental health services and substance abuse treatment services are provided in the planning of treatment and the delivery of services.

(D) The system provides for the development and implementation of individualized treatment plans by multidisciplinary and multiagency teams, which are recognized and followed by the applicable agencies and providers in the area.

(E) The system ensures the delivery and coordination of the range of mental health services and substance abuse treatment services required by individuals under 22 years of age who have a serious emotional disturbance or a substance abuse disorder.

(F) The system provides for the management of the individualized treatment plans described in subparagraph (D) and for a flexible response to changes in treatment needs over time.

(c) TREATMENT OF EXPERIMENTAL SERVICES.—In applying subsection (a), the Board shall make national coverage determinations with respect to those services that are experimental in nature. Such determinations shall be made consistent with a process that provides for input from representatives of health care professionals and patients and public comment.

(d) APPLICATION OF PRACTICE GUIDELINES.—In the case of services for which the American Health Security Quality Council (established under section 1401) has recognized a national practice guideline, the services are considered to meet the standards specified in section 1101(a) if they have been provided in accordance with such guideline or in accordance with such guidelines as are provided by the State health security program consistent with subtitle E. For purposes of this subsection, a service shall be considered to have been provided in accordance with a practice guideline if the health care provider providing the service exercised appropriate professional discretion to deviate from the guideline in a manner authorized or anticipated by the guideline.

(e) SPECIFIC LIMITATIONS.—

(1) LIMITATIONS ON EYEGLASSES, CONTACT LENSES, HEARING AIDS, AND DURABLE MEDICAL EQUIPMENT.—Subject to section 1101(e), the Board may impose such limits relating to the costs and frequency of replacement of eyeglasses, contact lenses, hearing aids, and durable medical equipment to which individuals enrolled for benefits under this title are entitled to have payment made under a State health security program as the Board deems appropriate.

(2) OVERLAP WITH PREVENTIVE SERVICES.—The coverage of services described in section 1101(a) (other than paragraph (3)) which also are preventive services are required to be covered only to the extent that they are required to be covered as preventive services.

(3) MISCELLANEOUS EXCLUSIONS FROM COVERED SERVICES.—Covered services under this title do not include the following:

(A) Surgery and other procedures (such as orthodontia) performed solely for cosmetic purposes (as defined in regulations) and hospital or other services incident thereto, unless—

(i) required to correct a congenital anomaly;

(ii) required to restore or correct a part of the body which has been altered as a result of accidental injury, disease, or surgery; or

(iii) otherwise determined to be medically necessary and appropriate under section 1101(a).

(B) Personal comfort items or private rooms in inpatient facilities, unless determined to be medically necessary and appropriate under section 1101(a).

(C) The services of a professional practitioner if they are furnished in a hospital or other facility which is not a participating provider.

(f) NURSING FACILITY SERVICES AND HOME HEALTH SERVICES.—Nursing facility services and home health services (other than post-hospital services, as defined by the Board) furnished to an individual who is not described in section 1103(a) are not covered services unless the services are determined to meet the standards specified in section 1101(a) and, with respect to nursing facility services, to be provided in the least restrictive and most appropriate setting.

SEC. 1105. CERTIFICATION; QUALITY REVIEW; PLANS OF CARE.

(a) CERTIFICATIONS.—State health security programs may require, as a condition of payment for institutional health care services and other services of the type described in such sections 1814(a) and 1835(a) of the Social Security Act, periodic professional certifications of the kind described in such sections.

(b) QUALITY REVIEW.—For requirement that each State health security program establish a quality review program that meets the requirements for such a program under subtitle E, see section 1304(b)(1)(H).

(c) PLAN OF CARE REQUIREMENTS.—A State health security program may require, consistent with standards established by the Board, that payment for services exceeding specified levels or duration be provided only as consistent with a plan of care or treatment formulated by one or more providers of the services or other qualified professionals. Such a plan may include, consistent with subsection (b), case management at specified intervals as a further condition of payment for services.

Subtitle C—Provider Participation

SEC. 1201. PROVIDER PARTICIPATION AND STANDARDS.

(a) IN GENERAL.—An individual or other entity furnishing any covered service under a State health security program under this title is not a qualified provider unless the individual or entity—

(1) is a qualified provider of the services under section 1202;

(2) has filed with the State health security program a participation agreement described in subsection (b); and

(3) meets such other qualifications and conditions as are established by the Board or the State health security program under this title.

(b) REQUIREMENTS IN PARTICIPATION AGREEMENT.—

(1) IN GENERAL.—A participation agreement described in this subsection between a State health security program and a provider shall provide at least for the following: